No. 19-10011

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

TEXAS, *et al.*,
Plaintiffs-Appellees,
v.

UNITED STATES, *et al.*,
Defendants-Appellants.

THE STATES OF CALIFORNIA, *et al.*,
Intervenors-Defendants-Appellants.

On Appeal from the United States District Court
for the Northern District of Texas
No. 4:18-cv-167-O
Hon. Reed O'Connor, Judge

STATE DEFENDANTS' OPPOSED MOTION TO EXPEDITE APPEAL

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February 1, 2019

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The States of California, Connecticut, Delaware, Hawaii, Illinois, Kentucky, Massachusetts, Minnesota (by and through its Department of Commerce), New Jersey, New York, North Carolina, Oregon, Rhode Island, Vermont, Virginia, and Washington, and the District of Columbia respectfully move this Court to expedite this appeal, set a briefing schedule, and set this case for oral argument as soon as practicable upon the completion of briefing under Federal Rule of Appellate Procedure 45(b)(2) and Fifth Circuit Rule 47.7.

1. The district court in this case entered a judgment declaring invalid the Patient Protection and Affordable Care Act (ACA) of 2010, a landmark piece of legislation that has transformed the nation's healthcare system. To date, nearly 12 million Americans have gained health insurance through the ACA's expansion of the Medicaid program, while over eight million others have received ACA-funded tax credits that have enabled them to purchase health insurance through the "Exchanges" established by the Act. D.Ct. Dkt. 91-1 at 14, 17, 66-67.[1] The ACA has also protected the 133 million Americans—including 17 million children—with preexisting health conditions by guaranteeing that insurance companies cannot charge them higher rates because of their poor health, or refuse to insure

[1] Citations to "D.Ct. Dkt." are to the docket in Northern District of Texas Case No. 18-cv-167-O. Exchanges are "marketplace[s] that allow people to compare and purchase insurance plans." *King v. Burwell*, 135 S. Ct. 2480, 2485 (2015).

them on that basis. *Id.* at 14. And it has slowed the growth of premiums for health insurance plans offered through employers. *Id.* at 12.

The district court held that one provision of the Act—a requirement that most individuals maintain health insurance or pay a modest tax—became unconstitutional when Congress reduced the amount of the tax to zero. D.Ct. Dkt. 211 at 34, 55. It further held the remainder of the ACA inseverable, and that the entire Act is therefore invalid. *Id.* at 54-55. Because of the tremendous disruption and harm that implementation of that decision would have caused, the court stayed its judgment pending immediate appellate review. D.Ct. Dkt. 220. The State Defendants and the Federal Defendants filed their notices of appeal on January 3 and 4, 2019, respectively. On January 7, the United States House of Representatives moved to intervene in this appeal; and on January 31, the States of Colorado, Iowa, Michigan, and Nevada filed a separation motion to intervene. This matter was stayed from January 11 to January 29 because of the expiration of the appropriations act that had been funding the U.S. Department of Justice.

2. The State Defendants respectfully ask this Court to expedite this appeal to allow for prompt resolution of this exceptionally important case. *See* Fed. R. App. P. 45(b)(2); Fifth Cir. R. 47.7. The ACA restructured nearly one-fifth of the nation's economy, and is a central pillar of our healthcare system. D.Ct. Dkt. 91-2 at 164. A wide range of fiscal, regulatory, and individual decisions depend on the

outcome of this appeal. For example, the Act directs tens of billions of dollars to States each year through its provisions expanding Medicaid and creating other public health programs. *See* D.Ct. Dkt. 91-1 at 33-66 (State Defendants would lose $608.5 billion in federal funds between 2019 and 2028 if district court's decision is affirmed); Blewett Declaration ¶ 10; Gobeille Declaration ¶ 3. State lawmakers depend on the availability of those funds when setting their budgets, a process that takes months. Gobeille Declaration ¶ 5; Sherman Declaration ¶ 6. Similarly, state regulators begin working with insurers to set health insurance premiums well before those prices take effect. Bertko Declaration ¶ 6; Sherman Declaration ¶ 10. And when an insurer wants to develop and market an innovative product or change the way its service provider network is designed, planning can start up to 24 months in advance. Corlette Declaration ¶ 4. The availability of high quality, affordable healthcare coverage also influences countless individual decisions, including whether to move, change jobs, or start a family. *See generally* D.Ct. Dkt. 91-1 at 13-22.

The decision below creates substantial uncertainty about these and other choices. Indeed, that uncertainty has already led some States to begin to investigate additional measures they might take to stabilize their healthcare markets. Gobeille Declaration ¶¶ 6, 7; Sherman Declaration ¶ 7. The shadow cast by the decision below may also negatively impact the health insurance market in

future years by, for example, causing insurers to increase premiums or withdraw from the Exchanges altogether. Bertko Declaration ¶ 4; Blewett Declaration ¶¶ 6-7; Corlette Declaration ¶ 7; Gobeille Declaration ¶ 4. A prompt resolution of this appeal will provide some measure of certainty about the future of the ACA to States, insurers, and ordinary Americans, and allow them to plan accordingly. Bertko Declaration ¶¶ 3, 6; Blewett Declaration ¶¶ 3, 9; Corlette Declaration ¶ 3; Sherman Declaration ¶¶ 5, 10; D.Ct. Dkt. 91-1 at 8-13.[2]

In light of these considerations, the State Defendants respectfully request that the Court adopt the following briefing schedule:

- March 29, 2019: State Defendants' and Federal Defendants' Opening Briefs Due
- May 1, 2019: Plaintiffs' Answering Brief Due
- May 22, 2019: State Defendants' and Federal Defendants' Reply Briefs Due

The State Defendants further request that this Court schedule this appeal for oral argument as soon as practicable upon the completion of briefing.

3. The Federal Defendants do not object to the schedule set forth in this motion. In light of the importance of this case, the Federal Defendants request that

[2] For the same reasons, the Court should not wait to set a briefing schedule until the pending motions to intervene are resolved. As noted below, all proposed intervenors—the House of Representatives and the States of Colorado, Iowa, Michigan, and Nevada—consent to this motion.

this Court set the case for oral argument during its hearings set for the week of July 8, 2019. The Federal Defendants suggest that, if the proposed schedule is modified to provide Plaintiffs-Appellees with more time to file their briefs, the schedule be modified in a manner that would still allow argument to proceed that week, such as by setting the deadline for Opening Briefs on March 15, 2019, and otherwise adopting the schedule proposed in this motion. The State Defendants do not object to the Federal Defendants' request to set this case for oral argument the week of July 8. However, given the exceptional importance of this case, and the complex issues it presents, they respectfully request that the Court not set the date due for the Opening Briefs prior to March 29, 2019.[3]

The State Plaintiffs and the Individual Plaintiffs oppose this motion, and plan to file written responses. Proposed-Intervenor the House of Representatives consents to this motion. Proposed-Intervenors the States of Colorado, Iowa, Michigan, and Nevada also consent to this motion.

[3] Indeed, the State Defendants' brief will likely address a wider range of issues than the Federal Defendants' brief, because the Federal Defendants conceded several of the issues raised by this case in the court below. *See* D.Ct. Dkt. 211 at 12 (noting Federal Defendants' agreement with Plaintiffs' position that the ACA's requirement to maintain health insurance or pay a modest tax is now unconstitutional, and that certain parts of the Act are inseverable from that requirement).

CONCLUSION

This Court should expedite this appeal, adopt the State Defendants' proposed briefing schedule, and set this case for oral argument as soon as practicable upon the completion of briefing.

Dated: February 1, 2019

Respectfully submitted,

s/ Samuel P. Siegel

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CERTIFICATE OF COMPLIANCE

I hereby certify that this brief complies with the requirements of Federal Rule of Appellate Procedure 27(d)(2) and Fifth Circuit Rule 27.4, because it contains 1,254 words, according to the count of Microsoft Word. I further certify that this brief complies with typeface requirements of Rule 27(d)(1)(E) because it has been prepared in 14-point Times New Roman font.

Dated: February 1, 2019

/s Samuel P. Siegel
Samuel P. Siegel

CERTIFICATE OF SERVICE

I certify that on February 1, 2019, I electronically filed the foregoing Motion to Expedite Appeal with the Clerk of the Court of the United States Court of Appeals for the Fifth Circuit by using the appellate CM/ECF system. I certify that all other participants in this case, except for the Individual Plaintiffs, are registered CM/ECF users and that service of those parties will be accomplished by the appellate CM/ECF system. I further certify that counsel for the Individual Plaintiffs was served via U.S. Mail. A declaration of service to counsel for the Individual Plaintiffs is attached.

Dated: February 1, 2019

/s Samuel P. Siegel
Samuel P. Siegel

DECLARATION OF SERVICE BY U.S. MAIL

Case Name: **Texas v. United States**

No.: **19-10011 5th Circuit**

I declare:

I am employed in the Office of the Attorney General, which is the office of a member of the California State Bar, at which member's direction this service is made. I am 18 years of age or older and not a party to this matter. I am familiar with the business practice at the office of the Attorney General for collection and processing of correspondence for mailing with the United States Postal Service. In accordance with that practice, correspondence placed in the internal mail collection system at the Office of the Attorney General is deposited with the United States Postal Service with postage thereon fully prepaid that same day in the ordinary course of business.

On February 1, 2019, I served the attached **STATE DEFENDANTS' OPPOSED MOTION TO EXPEDITE APPEAL** by placing a true copy thereof enclosed in a sealed envelope in the internal mail collection system at the Office of the Attorney General at 1300 I Street, Suite 125, P.O. Box 944255, Sacramento, CA 94244-2550, addressed as follows:

ROBERT EARL HENNEKE
Texas Public Policy Foundation
901 N. Congress Avenue
Austin, TX 78701
(512) 472-2700
Rhenneke@texaspolicy.Com

I declare under penalty of perjury under the laws of the State of California the foregoing is true and correct and that this declaration was executed on February 1, 2019, at Sacramento, California.

A. Cerussi	*/s/ A. Cerussi*
Declarant	Signature

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ADDENDUM

TABLE OF CONTENTS

Page

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DECLARATION OF JOHN BERTKO IN SUPPORT OF STATE DEFENDANTS' MOTION TO SET EXPEDITED BRIEFING SCHEDULE AND FOR CALENDARING PRIORITY

I, John Bertko, declare:

1. I am an independent actuarial consultant currently working as the Chief Actuary for Covered California, a position I have held since 2014. As the Chief Actuary, I am responsible for measuring the risk profile of enrollees on California's Exchange and advising the Covered CA management team on issues regarding the plans' development of premium, as well as maintaining stability of the California market. I also direct research and analysis into the state and national health insurance marketplaces in order to understand how federal and state policy changes will impact the market, including the cost of health insurance. Prior to working for Covered California, I served as Director of Special Initiatives and Pricing in the Center for Consumer Information and Insurance Oversight at the Centers for Medicare and Medicaid Services from 2011 to 2014. Before that I was Chief Actuary at Humana, where I managed the corporate actuarial group and directed work by actuarial staff for Humana's major business units. I am a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. I received my bachelor's degree in mathematics from Case Western Reserve University. I am a member of the CBO's Panel of Health Advisors and served as commissioner on the Medicare Payment Advisory Commission for six years.

2. Since 2014, Covered California has functioned as California's state health insurance exchange under the Affordable Care Act (ACA). In 2018, Covered California served 1.4 million consumers, making it the largest state-based health insurance exchange and second largest health insurance exchange overall in the country.

3. The health insurance market in California, as well as similar markets across the nation, will benefit from the certainty that will come from a resolution of the legal questions at issue in this case. Therefore, expediting the resolution of this matter will grant more stability to the marketplaces, which in turn will allow insurers and regulators to better set fair and accurate prices for health insurance.

4. Uncertainty as to the status of the constitutionality of the ACA makes it harder for insurers and Covered California to gauge what the insurance marketplace will look like in the coming years. Recent changes in federal policy and the resulting uncertainty have already resulted in increased premiums, as insurers raised prices to cover perceived additional risk. Because of the

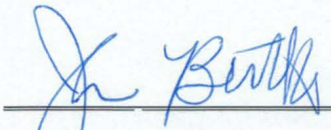
increased uncertainty regarding the validity of the ACA, insurers may raise premiums to cover the perceived additional risk.

5. Covered California's premium rates for the 2019 plan year increased by a statewide average of 8.7 percent. That figure includes an increase of 2.5 to 6 percent (3.5 percent on average) due to the repeal of the ACA's tax penalty for those who lack minimum creditable coverage. Insurers added this cost to premiums due to concerns that the elimination of the penalty would lead to fewer enrollees and a sicker and costlier risk pool.

6. Insurers are required to submit final proposed premium rates to Covered California on July 8, 2019 for the 2020 benefit year. An expedited resolution of this matter would allow both California insurers and Covered California to have a greater degree of certainty in setting these rates. The marketplace stability provided by an accelerated resolution to the legal questions at issue in this case would alleviate insurer uncertainty and allow insurers and regulators to remove any unnecessary risk margins and better set fair and accurate prices for health insurance for 2020.

I declare under penalty of perjury under the laws of the United States and the State of California that the foregoing is true and correct to the best of my knowledge.

Executed on February 1, 2019, in Pacific Grove, California.



John Bertko
Chief Actuary
Covered California

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DECLARATION OF LYNN A. BLEWETT IN SUPPORT OF STATE DEFENDANTS' MOTION TO SET EXPEDITED BRIEFING SCHEDULE AND FOR CALENDARING PRIORITY

I, Lynn A. Blewett, declare:

1. I am Mayo Professor of Health Policy at the University of Minnesota School of Public Health. I also direct the State Health Access Data Assistance Center (SHADAC) a multidisciplinary research and policy center that provides data analytics and policy analysis to inform evidenced-based health policy and has worked with states across the country on health care reform, policy analysis, and implementation of the Affordable Care Act (ACA).

2. I have over 25 years of health policy experience. I worked for Senator Dave Durenberger in the U.S. Senate, served as Minnesota's State Health Economist, and was appointed by Governor Mark Dayton to serve on the Minnesota Health Care Financing Task Force. I actively work with state policy analysts and decision makers to better understand trends in health insurance coverage, implementation of the ACA, Medicaid payment reform, and pressing issues facing state policy makers. I am a member of the National Academy of Social Insurance and have previously served on the Scientific Advisory Committee for the National Center for Health Statistics and on the boards of AcademyHealth and the University of Minnesota's teaching hospital. I have published dozens of peer-reviewed articles on health policy and health insurance markets. A full list of my publications is available in my CV, a true and correct copy of which is attached as Exhibit A. I have an MA in public affairs and a PhD in Health Services Research and Policy from the University of Minnesota.

3. I am familiar with the issues raised in this case. In my expert opinion, a final determination regarding the constitutionality of the individual mandate and its severability from the rest of the ACA is of significant concern to states and insurers. Expedited briefing will allow states and their health insurance markets to react adequately to a final determination.

4. States have put their full effort over the past 8 years into adapting their systems to comply with the many changes imposed by the ACA. To roll back all or even a small portion of these reforms would be devastating and costly to states. For example, 7 states applied for and received authority under Section 1332 of the ACA to implement reinsurance financing in the individual market using pass-through funding from federal premium subsidies. Pass-through

funding refers to the federal savings achieved from a reduction in premiums along with a reduction in federal premium subsidies for plans offered on the health insurance marketplace. As reinsurance had the impact of reducing premiums by an estimated 20% on average, federal premium subsidies offered on the health insurance marketplaces also went down. These federal savings are passed on to the states to help fund their reinsurance programs. If the ACA were deemed unconstitutional in its entirety, federal pass-through funding through 1332 waivers would no longer be available, creating havoc in those states that have developed these programs in good faith and with the understanding that the federal support would be available.

5. The individual market reforms are of utmost importance in terms of the timing of a final determination. The individual market has reached some level of stability and is working for the 8.4 million individuals who purchase subsidized coverage on the Health Insurance Marketplaces.

6. Financial stability in the markets is represented by improved medical loss ratios – now averaging 82% in 2017, down from a high of 103% in 2015 when plans were losing money. Lower medical loss ratios means that health plans are setting premiums at levels that now match more closely with their claims costs.[1] A lengthy disruption in this market at this time could prove devastating both for individuals and for the insurance companies who have invested in this market and stayed the course over the years of instability.

7. The premium setting process for CY 2020 has already begun, with initial premiums due later this spring. Not having a quick resolution to this case could cause some health plans to withdraw from the market, creating uncertainty and potentially resulting in an increase in premiums for those insurers who remain, in order to address the added instability and risk of doing business under a statutory and regulatory regime that might cease to exist.

8. The premium subsidies (Advanced Premium Tax Credits) are essential to the stability of the individual market and to affordable coverage for some 8 million individuals. If

[1] Cox, Cynthia, Ashley Semanskee, and Larry Levitt. Individual health insurance market performance, 2017. May 17, 2018, Kaiser Family Foundation Issue Brief. Available at: https://www.kff.org/private-insurance/issue-brief/individual-insurance-market-performance-in-2017/.

the ACA is deemed unconstitutional, states will need to act quickly to respond to an increase in the number of newly uninsured individuals. Action could include changes to existing state-funded public coverage programs but also addressing the expected and significant growth in uncompensated care provided by community hospitals. Already with the elimination of the tax penalty associated with the individual mandate, along with other administrative changes, including more flexibility for Association Health Plans and Short-Term Limited-Duration Plans, many individuals have already left the individual market and become uninsured. For the first time since the passage of the ACA, we are seeing an increase in the number of uninsured. A recent Gallup poll has shown a statistically significant increase in the uninsured in the last quarter of 2018: from a low of 10.9% in Q3 2016 to a recent high of 13.7% in Q4 of 2018 for U.S. adults, representing about seven million adults without health insurance coverage.[2]

9. While the individual market has achieved some stability, the Congressional Budget Office (CBO) reported that in 2018 26% of the population lived in counties with only one health insurer offering coverage (up from 19% in 2017).[3] According to the CBO, there continues to be significant uncertainty in the individual market about what additional changes might be made in federal rules. Adding to this uncertainty would be any delay in this case. Payers are watching closely and developing contingency plans regarding any forthcoming ruling. Additional delay only extends this period of uncertainty and instability in the individual market for payers and state regulators.

10. 37 states have enacted the optional Medicaid expansion under the ACA. This number includes 3 states (Idaho, Nebraska, and Utah) that passed ballot initiatives in November 2018 to expand, and Virginia, which began its expansion on January 2, 2019. The ACA allowed states to expand Medicaid to adults with incomes up to 138% of the FPL with the goal of

[2] Witters, Dan. U.S. Uninsured Rates Rise to Four-Year High. Gallup Well-Being. January 23, 2019. Available at: https://news.gallup.com/poll/246134/uninsured-rate-rises-four-year-high.aspx?g_source=link_NEWSV9&g_medium=TOPIC&g_campaign=item_&g_content=U.S.%2520Uninsured%2520Rate%2520Rises%2520to%2520Four-Year%2520High.

[3] CBO. Federal Subsidies for health insurance coverage for people under age 65: 2018-2028. Available at: https://www.cbo.gov/system/files?file=2018-06/53826-healthinsurancecoverage.pdf.

increasing access to affordable coverage for U.S. citizens and permanent residents. The Medicaid expansion currently covers millions of individuals with federal matching payments covering 90% of the costs of newly enrolled individuals. If states are required to roll back their Medicaid expansion, there would be a significant immediate impact on the number of uninsured, the levels of uncompensated care required by hospitals, and disruption to state Medicaid programs as they adjust their eligibility and enrollment systems.

I declare under penalty of perjury under the laws of the United States and the State of Minnesota that the foregoing is true and correct to the best of my knowledge.

Executed on January 30, 2019 in Minneapolis, Minnesota

Lynn A. Blewett
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University of Minnesota School of Public Health

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DECLARATION OF SABRINA CORLETTE IN SUPPORT OF STATE DEFENDANTS' MOTION TO SET EXPEDITED BRIEFING SCHEDULE AND FOR CALENDARING PRIORITY

I, Sabrina Corlette, declare:

1. I am a Research Professor at the Center on Health Insurance Reforms (CHIR) at Georgetown University's Health Policy Institute. At CHIR, I direct research on health insurance reform issues. My areas of focus include state and federal regulation of private health insurance plans and markets and evolving insurance market rules. I have published numerous papers relating to the regulation of private health insurance and health insurance marketplaces. Prior to joining the Georgetown faculty, I was Director of Health Policy Programs at the National Partnership for Women & Families, where I provided policy expertise and strategic direction for the organization's advocacy on health care reform, with a particular focus on insurance market reform, benefit design, and the quality and affordability of health care. I also served as an attorney at Hogan Lovells, during which time I advised clients on health insurance, health finance, and food and drug regulatory matters.

2. Since 2010, I have authored over 25 research papers about the Affordable Care Act and its implementation. I have been invited to testify as an Affordable Care Act expert before seven congressional committees (U.S. House of Representatives and U.S. Senate) in the last five years. The California General Assembly invited me in January 2018 to testify about the status of the individual health insurance market. I regularly provide technical assistance to state departments of insurance, state policymakers, and other health care organizations regarding Affordable Care Act regulations and guidance and their impact on consumers and other health care stakeholders. I am frequently consulted by journalists seeking Affordable Care Act expertise, and have been quoted numerous times on health insurance and Affordable Care Act issues in national and local print, radio, web-based, and television media. A full list of my publications and media is available on our website at https://chir.georgetown.edu.

3. The Affordable Care Act (ACA) established state-based marketplaces where insurers compete for enrollees on price and quality. In my expert opinion, a rapid resolution to the issues in this case would increase the stability of the health insurance markets by giving insurers the

time they need to develop new policies, set rates, and determine whether they will participate in the individual marketplaces.

4. Under normal circumstances, insurers start collecting key data and making strategic business decisions about participation, service areas, network designs, medical management strategies, and investments in marketing and customer service systems as much as 18 months in advance of issuing a policy. So the product teams at insurers considering marketplace participation in 2020 have already been meeting for several months. (When an insurer wants to develop and market an innovative product, provider network design, or managed care program, planning can start up to 24 months in advance.) Further, these companies are making decisions about their future products under the scope of existing federal and state rules, such as the requirements to cover a minimum set of essential benefits, meet actuarial value targets, and maintain adequate provider networks. Should those rules change, insurers will be forced back to the drawing board. Insurers' plans will be thrown into even greater confusion, should the entire ACA be ruled unconstitutional or enjoined.

5. Determining a price for these products also takes many months, and the greater the uncertainty injected into the pricing process, the higher the price will be. To develop an actuarially sound premium rate for 2020, most health actuaries will start assembling the required enrollment, claims, financial, and other data from 2018 in early to mid-February 2019. Insurers will then hone those rates based on their marketing strategy and emerging data about the past year's claims experience and financial performance, both their own and their competitors'. The federal deadline for submitting 2020 rates for regulatory review has been tentatively set for July 24, 2019; many states require earlier submission deadlines.

6. Many state regulators will allow insurers to subsequently adjust their rates, but typically only in the event of major changes in public policy or in the market. This occurred in 2016, for instance, when a number of insurers increased their rates after the filing deadline following the exit of major competitors from the market. Insurers also may be allowed to adjust rates in the wake of an unexpected charge under the ACA's risk adjustment program, which

redistributes funds from insurers with lower-risk enrollees to insurers with higher-risk enrollees. Under the current draft regulatory timeline, the federal marketplace will consider insurers' plan prices to be final by August 21, 2019. Insurers then have until September 24, 2019 to decide whether to commit to the marketplaces, scale back their participation, or exit completely. State regulators are already challenged to conduct the necessary reviews within the current time frames, and it takes time to ensure that final plan designs and rates are loaded into and accurately displayed on the marketplace websites.

7. Insurers are capable of responding to changes in the legal and competitive environment, but their flexibility has limits and they are under tight timelines. Uncertainty about the rules under which they will operate in the future gives rise to uncertainty about how market competitors and current and potential enrollees will respond. This, in turn, will lead some insurers to scale down their marketplace participation or to leave the market entirely in 2020. Those that stay will need to factor the increased risk they face into the premiums they set.

I declare under penalty of perjury under the laws of the United States and the State of California that the foregoing is true and correct to the best of my knowledge.

Executed on January 31, 2019, in Washington, D.C.

Sabrina Corlette
Center on Health Insurance Reforms
Georgetown University

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DECLARATION OF ALFRED J. GOBEILLE IN SUPPORT OF STATE DEFENDANTS' MOTION TO SET EXPEDITED BRIEFING SCHEDULE AND FOR CALENDARING PRIORITY

I, Alfred J. Gobeille, declare:

1. I am the Secretary of the Vermont Agency of Human Services (AHS). I have served in this position since January 2017. AHS was created by the Vermont Legislature in 1969 to serve as the umbrella organization for all human service activities within state government. AHS is led by the Secretary, who is appointed by the Governor. The Secretary's Office is responsible for leading the agency and its departments: the Department for Children and Families; the Department of Corrections, the Department of Disabilities, Aging and Independent Living; the Department of Mental Health; and the Department of Vermont Health Access (DVHA). DVHA is the state office responsible for the management of Medicaid, the State Children's Health Insurance Program, and other publicly funded health insurance programs in Vermont. As such, it is the largest insurer in Vermont in terms of dollars spent and the second largest insurer in terms of covered lives. DVHA is responsible for administering Vermont Health Connect, which is the State's health insurance marketplace. I have either personal knowledge of the matters set forth below or, with respect to those matters for which I do not have personal knowledge, I have reviewed information gathered from AHS records and other publicly available information. This declaration is submitted in support of the State Defendants' Motion to Set an Expedited Briefing Schedule and for Calendaring Priority.

2. As of June 2018, 27,123 individuals obtained health insurance through Vermont Health Connect. 22,128 of them (81.6%) received federal tax subsidies to defray the cost of premiums. Each county in Vermont has only two insurers offering coverage through Vermont Health Connect. The loss of even a single insurer would negatively impact the stability and competitiveness of Vermont's health insurance markets.

3. If the district court's decision in this case is upheld on appeal, it would cause severe harm to the State of Vermont, to its residents, and to its economy. In addition to loss of benefits and services and federal investments to support Vermont's healthcare system, dismantling or suspending implementation of the Affordable Care Act (ACA) would cause Vermont to

experience harm and increased costs from the dismantling of the State's own administrative structure and apparatus, created in compliance with, and to work in conjunction with, the ACA.

a. **The ACA directs hundreds of millions of dollars directly to Vermont via Medicaid expansion, the Public Health Fund, and for federal premium subsidies.**

b. **The ACA increased access to affordable coverage.**

i. Overall the number of individuals with insurance has increased. In Vermont, the number of covered individuals increased from 583,674 in 2012 to 604,800 in 2018, according to the 2018 Vermont Household Health Insurance Survey (VHHIS). Over the same period, the number of uninsured Vermonters was more than cut in half, dropping from 42,800 in 2012 to 19,800 in 2018. This correlates to an uninsured rate of 6.8% in 2012 and 3.2% in 2018.

ii. The ACA expanded coverage through two key mechanism: Medicaid expansion for those individuals with the lowest incomes, and federal health subsidies to purchase coverage in new health insurance Exchanges, like Vermont Health Connect, for those individuals with moderate incomes.

iii. Medicaid is an important source of healthcare insurance coverage and has resulted in significant coverage gains and reduction in the uninsured rate, both among the low-income population and within other vulnerable populations. Vermont can be described as a "pre-expansion" state in the sense that it offered state health programs—the Vermont Health Access Plan and Catamount Health—to Vermonters with incomes up to 300% of the federal poverty level (FPL) years before Medicaid expansion. The change in Medicaid eligibility under the ACA from considering assets to only focusing on income also benefitted farmers and other land rich, cash

poor Vermonters who previously could not afford health insurance and did not qualify for benefits, but now qualify either for Medicaid or for health insurance subsidies. The uninsured rate for Vermonters with income up to 138% FPL (the expanded Medicaid threshold) dropped from 9.6% in 2012 to 2.0% in 2018. Significantly, by 2018, the most economically vulnerable Vermonters were just as likely to have health coverage as high-income Vermonters.

iv. Creation of health insurance exchanges is an important reform made by the ACA. In Vermont, as of June 2018, 22,128 people received federally subsidized coverage as a result of the ACA.

c. **The ACA has positive economic benefits on states.**

i. Studies have shown that states expanding Medicaid under the ACA , including Vermont, have realized budget savings, revenue gains, and overall economic growth.

d. **The ACA expanded programs in Medicaid to provide States with increased opportunities to increase access to home and community-based services.**

i. In 2011, Vermont was awarded a five-year $17.9 million Money Follows the Person (MFP) grant from CMS to help people living in nursing facilities overcome the barriers that have prevented them from moving to their preferred community-based setting. The grant works within the Choices for Care program and provides participants the assistance of a Transition Coordinator and up to $2,500 to address barriers to transition.

ii. Effective April 1, 2016, Vermont received a continued $8 million award for services through September 30, 2019.

e. **The ACA resulted in better quality and more accessible, affordable healthcare for consumers.**

i. The ACA created robust consumer protections to help ensure individuals can access the healthcare system.

ii. Largely due to the ACA's provision that adult children can be covered by their parents' health plan until age 26, the number of uninsured young adults in Vermont between the ages of 18 and 24 was slashed from 10,800 in 2009 to 1,900 in 2018;

iii. More than 78,000 Vermonters enrolled in qualified health plans as of June 2018 are benefitting from the ACA's mandated preventive services, including access to birth control, cancer screenings, and immunizations for children;

iv. More than 78,000 Vermonters enrolled in qualified health plans as of June 2018 are benefitting from access to essential health benefits such as substance use disorder treatment and cancer screenings.

v. The ACA has led to improved access to care (45% drop from 2009 to 2018 in the number of individuals who needed medical care from a doctor but did not receive it because they could not afford it).

vi. The ACA has led to improved financial security for Vermont families. The number of Vermonters who had trouble paying medical bills fell more than 40,000 from 2009 to 2018, a 30% drop. In addition, the number of Vermonters who were contacted by a collection agency about owing money for unpaid medical bills fell by 22% over the same period.

vii. Under the ACA, no individual can be rejected by an insurance plan or denied coverage of essential health benefits for any health condition present prior to the start of coverage. Once enrolled, plans cannot deny coverage or raise rates based only on the enrollee's health.

viii. In addition, the ACA created additional consumer protections and rights such as: ending lifetime and yearly dollar limits on coverage of essential

health benefits; improving consumer understanding of the coverage they are getting; holding insurance companies accountable for rate increases; making it illegal for health insurance companies to cancel health insurance due to illness; protecting patient choice of doctors; and free access to breastfeeding equipment and support; the right to appeal a health plan decision.

4. Beyond the impact of striking down the entire ACA, the very threat of that looming possibility may negatively impact the health insurance market in Vermont. Our health insurance market, as well as similar markets across the nation, will benefit from the certainty that will come from a resolution of the legal questions at issue in this case. Therefore, an expedited decision will grant a degree of stability to the marketplaces, which in turn will allow insurers and regulators to set fair and accurate prices for health insurance as they plan for the 2020 plan year and beyond.

5. Certainty and the ability to plan ahead is especially important in a small state such as Vermont. Our State's General Assembly is a part-time Legislature, and is generally in session from January through May. Budget articles are prepared in the fall of the preceding year and are voted on in April and May after vetting through various committees. Once the General Assembly adjourns (usually in May), it does not reconvene until the following January except in extraordinary circumstances, making it difficult to adapt to major and sudden federal policy changes that impact Vermonters.

6. Uncertainty as to the status of federal health law and policy, including questions about the constitutionality of the ACA and its implementing regulations, also makes it harder for insurers and the State to gauge what the insurance marketplace will look like in the coming years. Because of this increased sense of uncertainty, DVHA has engaged stakeholders in contingency planning and is considering market stabilization initiatives. In turn, the task of preparing and approving insurance premium rates has become more complicated and time-

consuming, because both insurers and the State are operating without full knowledge of the effects of sudden legal or policy changes.

7. Uncertainty as to the status of federal health law and policy additionally makes it difficult to plan and prioritize the costly IT infrastructure projects and maintenance needed to operate Vermont's health insurance programs effectively and in compliance with the appropriate regulations. Changes in federal policy and the surrounding uncertainty have already resulted in increased premiums, as insurers raise prices to cover perceived additional risk. For example, qualified health plan premium rates approved for the 2019 plan year included an increase of 1.6% due the zeroing out of the ACA's tax penalty for those who lack minimum essential coverage. Although the Vermont Legislature recently enacted a state-level individual mandate, it is not scheduled to go into effect until 2020. *See* 2018 Vt. Acts & Resolves No. 182.

I declare under penalty of perjury under the laws of the United States and the State of Vermont that the foregoing is true and correct to the best of my knowledge.

Executed on February 1, 2019, in Waterbury, Vermont.

Alfred J. Gobeille
Secretary, Vermont Agency of Human Services

No. 19-10011

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

TEXAS, *et al.*,
Plaintiffs-Appellees,

v.

UNITED STATES, *et al.*,
Defendants-Appellants.

THE STATES OF CALIFORNIA, *et al.*,
Intervenors-Defendants-Appellants.

On Appeal from the United States District Court
for the Northern District of Texas
No. 4:18-cv-167-O
Hon. Reed O'Connor, Judge

DECLARATION OF ZACHARY W. SHERMAN, DIRECTOR OF THE STATE OF RHODE ISLAND'S STATE-BASED HEALTH INSURANCE EXCHANGE HEALTHSOURCE RI, IN SUPPORT OF STATE DEFENDANTS' MOTION TO SET EXPEDITED BRIEFING SCHEDULE AND FOR CALENDARING PRIORITY

I, Zachary W. Sherman, declare:

1. I am the Director of HealthSource RI (HSRI), Rhode Island's state-based health insurance exchange. I have been Director for over three years, and have served in multiple capacities at HealthSource RI since shortly after the Affordable Care Act passed in 2010.

2. Over 32,000 Rhode Islanders purchase health insurance through HSRI, and 83 percent of those enrollees receive Advance Premium Tax Credits (APTCs) to help them afford their premiums. In 2018 alone, Rhode Islanders enrolled in health plans through HSRI received $98,953,384.73 in APTCs. Rhode Island's five counties (Bristol, Providence, Kent, Washington, and Newport) each have two insurers offering coverage through HSRI. The loss of even a single insurer would negatively impact the stability and competitiveness of Rhode Island's health insurance individual and small group markets.

3. For fiscal year 2018, HSRI's general revenue appropriation was $2,525,271 and its carrier assessment fees were $6,167,735. For fiscal year 2019, HSRI's general revenue appropriation is $2,363,841, and it expects its carrier assessment fees to total $6,708,627. The carrier assessment fees and general revenue appropriations help fund HSRI's operations so that it is able to connect Rhode Islanders with affordable health plans and continue to reduce the number of uninsured residents in the State.

4. If the District Court's decision to strike down the entire Patient Protection and Affordable Care Act (ACA) is upheld on appeal, every Rhode Islander enrolled through HSRI will lose their health insurance coverage. The APTCs that Rhode Islanders received last year in the amount of $98,953,384.73 will no longer be available, and HSRI will likely lose all its State funding, including general revenue appropriations and carrier assessment fees.

5. Beyond the impact of striking down the entire ACA, the very threat of that looming possibility may negatively impact the health insurance market in Rhode Island in 2020. Our health insurance market, as well as similar markets across the nation, will benefit from the certainty that will come from a resolution of the legal questions at issue in this case. Therefore, an expedited decision will grant a degree of stability to the marketplaces, which in turn will

allow insurers and regulators to set fair and accurate prices for health insurance as they begin planning for the 2020 plan year.

6. Certainty and the ability to plan ahead is especially important in a small state such as Rhode Island. Our State's General Assembly is a part-time Legislature, in session from January through June. Budget articles are introduced in late January and voted on in June after vetting through various committees. Once the General Assembly completes and adjourns session in June, they do not reconvene until the following January, making it difficult to adapt to major and sudden federal policy changes that impact Rhode Islanders.

7. Uncertainty as to the status of federal health law and policy, including questions about the constitutionality of the ACA and its implementing regulations, also makes it harder for insurers and HSRI to gauge what the insurance marketplace will look like in the coming years. Because of this increased sense of uncertainty, HSRI has done extensive stakeholder outreach and engagement, taken steps to mitigate the impact of the federal government's decision to discontinue making Cost Sharing Reduction payments, and engaged in analyses concerning the potential effects of federal policy changes on premium rates in Rhode Island. In turn, the task of preparing and approving insurance premium rates has become more complicated and time-consuming, because both insurers and State agencies are operating without full knowledge of the effects of sudden legal or policy changes.

8. Changes in federal policy and the surrounding uncertainty have already resulted in increased premiums, as insurers raise prices to cover perceived additional risk. These federal changes include federal regulatory efforts to expand and promote short-term, limited-duration health insurance and association health plans, and Congress's elimination of the ACA's penalty for not maintaining minimum essential coverage. Not all of these factors affect premiums in each state equally, but are generally expected to result in an increase in the uninsured. According to recent Gallup research, the uninsured rate in the United States increased more than 2 percent between the third quarter of 2016 and the fourth quarter of 2018. In Rhode Island, Governor Raimondo put forward a plan to combat the effects of these destabilizing policies. Her

2020 budget plan includes a proposal to: (1) institute a penalty for residents who do not maintain minimum essential coverage; (2) restrict the sale of short-term, limited duration health insurance plans; and (3) fund a state-based reinsurance program.

9. Rhode Island's individual market premium rates for the 2019 plan year increased by a statewide average of 8.1 percent. That figure includes a range of premium increases up to 1.9 percent due to the zeroing out of the ACA's tax penalty for those who lack minimum essential coverage. This cost was added to premiums due to concerns that the elimination of the penalty would lead to a sicker and costlier risk pool.

10. For the 2020 plan year, insurers are required to submit proposed premium rates by May of 2019. The State's Office of the Health Insurance Commissioner (OHIC) will review, request revisions and is expected to publish final 2020 rates by August of 2019. An expedited decision would allow both Rhode Island insurers and OHIC to have a greater degree of certainty in setting and finalizing these rates.

I declare under penalty of perjury under the laws of the United States and the State of Rhode Island that the foregoing is true and correct to the best of my knowledge.

Executed on February 1, 2019, in East Providence, Rhode Island.

Zachary W. Sherman